

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN lb <b>20 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>RFD # 1</b>		d. STREET ADDRESS <b>RFD # 1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LULU</b> Middle <b>ELIZABETH</b> Last <b>ACKER</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>13th</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1874</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul Feemster</b>		14. MOTHER'S MAIDEN NAME <b>Belle R. Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Donald Acker, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (b) <b>cerebral arteriosclerosis</b> (c) <b>331X</b> DUE TO <b>331X</b> (e), stating the underlying cause last. (c) <b>331X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's disease.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.		20d. INJURY OCCURRED <b>White</b> <input type="checkbox"/> <b>Not White</b> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19 56</b> to <b>Feb. 13</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9th</b> , 19 <b>62</b> , and that death occurred at <b>3:40</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Sohler</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.V. Sohler</b>		22d. ADDRESS <b>Delmar, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-16-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Melson</b>		23d. LOCATION (City, town or county) (State) <b>Delmar, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel Co.</b> ADDRESS <b>Delmar, Del.</b>		25a. REC'D BY REGISTRAR <b>FEB 16 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

VR A15 (4)  
15M 9/60

(M)

*Charles McArthur*  
*and his wife*

*Robertson Avenue*

*Feb 12 1924*  
*J. V. Schenck*

W. S. Harvey Co. Delmar, Del.

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82

1

VR A15 (4)  
15M 9/60

(M)

82

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02485

02475

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>5 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REHOBETH</u>		19X-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALLEN HERMAN Adams</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 13, 1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR &amp; BUILDER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>STEPHEN ADAMS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE MADDOX</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>214-13-4835</u>			
17. INFORMANT <u>CARL E. ADAMS, REHOBETH, MARYLAND.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>Multiple Myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/19</u> 19 <u>62</u> to <u>2/18</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> 19 <u>62</u> , and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				22b. DATE SIGNED <u>2/18/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL, JR.</u>				22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-21-62</u>		23c. NAME OF CEMETERY <u>PRESBYTERIAN</u>		23d. LOCATION (City, town or county) (State) <u>REHOBETH, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>				ADDRESS <u>Pocomoke City, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 62</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

(M)

(1)

02482

02482

March 13, 1971  
James M. Hanks  
214-13 West Court E. Hanks, Rembert, Maryland  
Thomas C. Hill, Jr.  
Rembert, Maryland  
Baltimore, Md.  
Baltimore City, Md.

James M. Hanks  
Rembert, Maryland  
March 13, 1971  
James M. Hanks  
Rembert, Maryland  
March 13, 1971  
James M. Hanks  
Rembert, Maryland

James M. Hanks  
Rembert, Maryland  
March 13, 1971  
James M. Hanks  
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James M. Hanks  
Rembert, Maryland  
March 13, 1971  
James M. Hanks  
Rembert, Maryland



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VR A15 (4)  
15M 9/59

02486

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02476

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>820 E.Church St</b>				1 d. STREET ADDRESS <b>820 E.Church St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>ARTHUR CLEVELAND ADKINS</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>FEBRUARY 5th 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1884</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. KIND OF BUSINESS OR INDUSTRY <b>Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>XXXXX Wicomico Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Trucking Co. Employee</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Noah James</b>				14. MOTHER'S MAIDEN NAME <b>Emma Layfield</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Mrs. Nettie B. Adkins (Wife)</b> Address <b>820 E.Church St Salisbury, Maryland</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>593X</b> <b>Wemic Poisoning</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic kidney failure</b> DUE TO (c) <b>Ageing process</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>N/A 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>				20f. (County) <b>N/A</b>		20f. (State) <b>N/A</b>	
21. I certify that (1) (this hospital) attended the deceased from <b>12/10/1961</b> to <b>2-5-1962</b> that (1) (we) last saw the deceased alive on <b>2-5-1962</b> and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. B. Smith</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 6, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. William B. Smith</b>				22d. ADDRESS <b>Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 8 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

1817

CERTIFICATE OF DEATH

03188



NAME OF DECEASED

RESIDENCE

1

DATE OF DEATH

830 F. COUNTY ST.

PLACE OF DEATH

ST. LOUIS, MO.

TIME OF DEATH

10:15 P.M.

CAUSE OF DEATH

HEART DISEASE

AGE

SEX

MALE

CERTIFICATE OF DEATH

03188

ST. LOUIS, MO.

10:15 P.M.

HEART DISEASE

MALE

830 F. COUNTY ST.

ST. LOUIS, MO.

10:15 P.M.

HEART DISEASE

MALE

830 F. COUNTY ST.

ST. LOUIS, MO.

10:15 P.M.

HEART DISEASE

MALE

830 F. COUNTY ST.

ST. LOUIS, MO.

10:15 P.M.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02487

02477

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsborg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box I06 Parsonsborg Md.</b>				d. STREET ADDRESS <b>Box I06 Parsonsborg Md</b>			
3. NAME OF DECEASED (Type or print) <b>Jennie Adkins</b>				4. DATE OF DEATH <b>February 18 1962</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 26, 1895</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Parker</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Ronald Parker Parsonsborg Md</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4-21-62</b> DUE TO <b>Chronic Endocarditis</b> Conditions, if any, which gave rise to immediate cause (b) <b>4-21-62</b> DUE TO <b>Chronic Endocarditis</b> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-15</b> , 19 <b>62</b> to <b>2-18</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>2-18</b> , 19 <b>62</b> and that death occurred at <b>2-21</b> , 19 <b>62</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur D. Browne</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-21</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arthur D. Browne</b>				22d. ADDRESS <b>Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/31/ 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glass Hill</b>		23d. LOCATION (City, town or county) (State) <b>Parsonsborg Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Clinton F. Stewart</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur D. Browne</b>	

VR A15 (4)  
15M 9/60

02173

12187



Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

Box 100 Wisconsin

Box 100 Wisconsin

ON

February

January

January

Box 100, 1900

Wisconsin

Wisconsin

January 1900

January 1900

No

1-15-12 2-11-12

1-15-12 2-11-12

United States  
District Court

Wisconsin

United States  
District Court

United States  
District Court

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

<div> <div>Items 18-21 Film 308 2-15-62 sms</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> </div>											
<div> <div>02488</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02478</div> </div>											
<div>1. PLACE OF DEATH</div> <div>a. COUNTY <u>Wicomico</u> <u>MARYLAND</u></div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u></div>					
<div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u></div>						<div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural)</u></div>					
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pineway</u></div>						<div>d. STREET ADDRESS <u>R.D.# 5 (Bennett Road)</u></div>					
<div>3. NAME OF DECEASED (Type or print) <u>LAWRENCE HAROLD ADKINS</u></div>						<div>4. DATE OF DEATH <u>FEBRUARY 24 19 62</u></div>					
<div>5. SEX <u>Male</u></div>		<div>6. COLOR OR RACE <u>White</u></div>		<div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH <u>June 19, 1912</u></div>		<div>9. AGE (In years last birthday) <u>49</u> yrs. <u>8</u> Months <u>5</u> Days</div>		<div>IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/></div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-Truck Body Building Works</u></div>						<div>11. BIRTHPLACE (State or foreign country) <u>Wicomico Co., Maryland</u></div>					
<div>12. CITIZEN OF WHAT COUNTRY? <u>U S A</u></div>											
<div>13. FATHER'S NAME <u>Sylvester Adkins</u></div>						<div>14. MOTHER'S MAIDEN NAME <u>Amelia C. Adkins</u></div>					
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u></div>						<div>16. SOCIAL SECURITY NO. <u>Mr. Marion C. Adkins (Brother) #Route #5 Bennett Road - Salisbury, Maryland</u></div>					
<div>17. INFORMANT <u>Mr. Marion C. Adkins (Brother) #Route #5 Bennett Road - Salisbury, Maryland</u></div>											
<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>3rd degree burns entire body</u></div> <div>916.0 DUE TO (b) _____</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____</div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute alcoholism</u></div> <div>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>											
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div>				<div>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found sitting in chair by stove in room that was completely burned</u></div>							
<div>20c. TIME OF INJURY Month, Day, Year <u>7:00 a.m. 2-24 1962</u></div>				<div>20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work</div>				<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u></div>			
				<div>20f. (City or town) <u>Wicomico</u> (County) <u>Md.</u> (State)</div>							
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div>											
<div>ACTUAL SIGNATURE <u>Philip A. Insley</u></div>				<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div>				<div>DATE SIGNED <u>Feb. 27/1962</u></div>			
<div>EXAMINER'S NAME (Type) <u>Dr. Philip A. Insley</u></div>				<div>M.D. <u>DEPUTY MEDICAL EXAMINER</u> <input checked="" type="checkbox"/></div>				<div>Address (Street, city, town, or county) <u>Main St. Salisbury, Maryland</u></div>			
<div>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></div>				<div>22b. DATE THEREOF <u>Feb. 27/1962</u></div>				<div>22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Church Cemetery-R.D.#Salisbury (Walston) Md.</u></div>			
<div>23. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY</u></div>				<div>ADDRESS <u>SALISBURY, MARYLAND</u></div>				<div>24a. REC'D BY REGISTRAR <u>MAR 2 '62</u></div>			
				<div>24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u></div>							

UNITED STATES  
DEPARTMENT OF HEALTH



02123

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

*Handwritten signature*



may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02479

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>234 North Blvd</b>				d. STREET ADDRESS <b>234 North Blvd.</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>RALPH</b> Last <b>ANDREWS</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>5th</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1893</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Salesman-Building Material</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Avondale, Pa.</b>		11. BIRTHPLACE (State or foreign country) <b>U S A</b>	
13. FATHER'S NAME <b>Charles H. Andrews</b>				14. MOTHER'S MAIDEN NAME <b>Eva Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>W.W.# I 222-09-8744</b>			
17. INFORMANT <b>Mrs. Katherine C. Andrews (Wife)</b>				Address <b>234 N. Blvd. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) <b>420.1</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>N/A 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2-5</b> 19 <b>62</b> to <b>2-5</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2-5</b> 19 <b>62</b> and that death occurred at <b>P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Wilbur R. Ellis Jr.</b>				22b. DATE <b>Feb. 6 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wilbur R. Ellis Jr.</b>				22d. ADDRESS <b>Medical Center-Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Feb. 8, 1962</b>		<b>Arlington Cemetery Co.</b>		<b>Drexel Hill, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>DATE FEB 8 '62</b>	

0513

CERTIFICATE OF DEATH

1913

Location

County

State

ON THIS DAY OF

1913

at the residence of the deceased

at

at

*[Handwritten signature]*

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02490

02480

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek, Md.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b>		c. LENGTH OF STAY IN 1b <b>7yrs5mo26days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Rural</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Alice D. Banning</b>		<b>4. DATE OF DEATH</b> Month <b>Feb.</b> Day <b>3,</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Sept. 2, 1968</b>
<b>9. AGE</b> (In years last birthday) <b>93</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>09</b> Days <b>12</b>	<b>IF UNDER 24 HRS.</b> Hours <b>00</b> Min. <b>00</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Vienna, Md.</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>U.S.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>Saul Willey</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Leah Hurley</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Edwin H. Banning, 414 Hughlett St., Camb., Md.</b>	
<b>17. INFORMANT</b> <b>Edwin H. Banning, 414 Hughlett St., Camb., Md.</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastro-intest. hemorrhage</b> (b) <b>541.0 DUE TO Duodenal ulcer</b> (c) <b>6 hrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>years</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>e.m.</b> <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>July 8, 1964</b> <b>to</b> <b>Feb. 3, 1962</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Feb. 3, 1962</b> , <b>and that death occurred at</b> <b>1:14PM</b> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>L. Maldve, M.D.</b>		<b>22b. DATE SIGNED</b> <b>Feb. 4, 1962</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>L. Maldve, M.D.</b>		<b>22d. ADDRESS</b> <b>Salisbury, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Feb. 6, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>East New Market Cemetery</b>		<b>23d. LOCATION (City, town or county)</b> <b>East New Market, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Reneeth R. Stevens</b>		<b>25. REC'D BY REGISTRAR</b> <b>Feb 7 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Harris</b>		<b>25c. REGISTRAR'S SIGNATURE</b>	

02150

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Campbell, No. 2

James K. Campbell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02491

02481

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>2 WKS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hosp. EAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Francis</u> Last <u>Barclay</u>				4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1875</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Lillian Nutter, Nanticoke Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2 Congestive heart failure</u> DUE TO (b) <u>degenerative heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr. 5 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia -</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13</u> to <u>2/13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> and that death occurred at <u>2:15</u> P.M. from the causes and on the date stated above.							
21a. SIGNATURE <u>Lillian Nutter</u>				21b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/18/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Nanticoke, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>BT Messing, Bivalve, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 19 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. France</u>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Warrant" and "Return" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN lb <b>254 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Tyaskin</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>										d. STREET ADDRESS <b>Route # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willie A. Barkley</b>				4. DATE OF DEATH <b>Feb. 9 19 62</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/4/1886</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Name</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>William Jones</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Jones</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Asbury Jones, White Haven, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Arteriosclerosis, general Conditons, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerosis, general</b> (c) <b>?</b>										INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>May 31, 1961</b> , to <b>Feb. 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9, 1962</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>V. Juerman</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>2/9/62</b>					
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>				22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/14/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>White Haven Cem.</b>				23d. LOCATION (City, town or county) (State) <b>White Haven, Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. J. W. Jones, Bivings, Md.</b>				ADDRESS <b>Bivings, Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>					

VR A15 (4)  
15M 9/60

US185

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02483

02493

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. LENGTH OF STAY IN 1b <u>32 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salisbury Rte. #1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>IDA</u> Last <u>BOUNDS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 22, 1879</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Mills</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Claude L. Bounds</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>? yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 60</u> to <u>Feb. 28</u> , 19 <u>62</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Feb. 19</u> , 19 <u>62</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Adkins</u>		22b. DATE SIGNED <u>26 Feb. 62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert T. Adkins</u> M.D.		22d. ADDRESS <u>Fruitland Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/28/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Allen, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 2 '62</u>	
ADDRESS <u>Salisbury Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

02130

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02494						02484					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Wicomico</u> MARYLAND						a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SALISBURY, MARYLAND</u>				d. STREET ADDRESS <u>Route 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <u>Wilmer Kent Bounds</u>						Month Day Year <u>Feb. 2nd 1962</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1894</u>		9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Siloam (Wico. Co.) Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ernest Bounds</u>						14. MOTHER'S MAIDEN NAME <u>Belle Bounds Bounds</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unk</u>				16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT Address <u>Mrs. Grace O. Bounds (Wife) R.D.# 1 (Siloam) Salisbury, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Generalized degenerative cardiovascular disease</u> DUE TO (c) <u>vascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <u>2/2</u> , 19 <u>62</u> to <u>2/2</u> , 19 <u>62</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>2/2</u> , 19 <u>62</u> , and that death occurred at <u>10:35 A</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>George H. Henning</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 2nd/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Henning</u>						22d. ADDRESS <u>Fruitland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>						ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Mather</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02485											
1. PLACE OF DEATH a. COUNTY Wicomico						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury						b. COUNTY Worcester					
c. LENGTH OF STAY IN lb						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL						d. STREET ADDRESS CEDAR AVENUE					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) IDA LEE BRITTINGHAM						4. DATE OF DEATH Month Day Year FEBRUARY 24 1962					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1875		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) BERLIN MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN M. RAYNE						14. MOTHER'S MAIDEN NAME ELLEN TIMMONS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. -		17. INFORMANT MR. LOUIS BRITTINGHAM WILLARDS MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-17, 1962 to 2-24, 1962, that (I) (we) last saw the deceased alive on 2-24, 1962, and that death occurred at 4 A.M. from the causes and on the date stated above.											
22a. SIGNATURE David J. Gilmore						M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/26/62		23c. NAME OF CEMETERY OR CREMATORY BUCKINGHAM		23d. LOCATION (City, town or county) BERLIN		(State) MD.			
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage						ADDRESS Berlin Md		25a. REC'D BY REGISTRAR DATE MAR 1 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MR. LAURENCE B. TITCHELL

James A. Garfield  
March 20/90

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MIRIAM</b> Middle <b>HUNTER</b> Last <b>BROGAN</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>15th</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1894</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>23</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Tarrytown, New York</b>		12. CITIZENSHIP OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Schumacher</b>		14. MOTHER'S MAIDEN NAME <b>Grace Abecrombie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>216-20-9132</b>	
17. INFORMANT <b>Mrs. Alexander R. Smith (Daughter) 511 Poplar Hill Ave. Salisbury, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b> 416X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 12 1962</b> to <b>Feb. 15 1962</b> that (I) (we) last saw the deceased alive on <b>Feb. 12 1962</b> and that death occurred <b>9:58 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>Feb. 15 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David J. Gilmore</b> <b>Dr. Wilbur R. Ellis</b>		22d. ADDRESS <b>Medical Center - Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 17/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Kensico Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Valhalla, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>FEB 19 '62</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

CERTIFICATE OF ORIGIN

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(M)

*[Faint, mostly illegible text and lines on a certificate form, likely containing fields for origin, date, and signature.]*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4



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## 0248'7

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.#</b>		d. STREET ADDRESS <b>R.D.#</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDNA</b>		Middle <b>MAE</b>		Last <b>BUDD</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. <u>MARRIED</u> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH Month <b>FEBRUARY</b>		Day <b>14th</b>		Year <b>1962</b>	
9. AGE (In years lost birthday) <b>58</b>		10. IF UNDER 1 YEAR Months <b>8</b>		Days <b>27</b>	
11. IF UNDER 24 HRS. Hours <b>8</b>		Minutes <b>27</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Ira Bownes</b>		14. MOTHER'S MAIDEN NAME <b>Annie Carey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mr. W. Charles Budd (Husband)</b>	
18. ADDRESS <b>Hebron, Maryland</b>		19. R.D.# <b>R.D.#</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart</b> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>24 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>		(County) <b>N/A</b>		(State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1962</b> to <b>Feb 14, 1962</b> , that (I) (we) lost saw the deceased alive on <b>Feb 1, 1962</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>H.S. Kuhlman</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 18, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. H.S. Kuhlman</b>		22d. ADDRESS <b>Sharptown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 18, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery (Old Section)</b>	
23d. LOCATION (City, town, or county) <b>Mardela, Maryland</b>		(State) <b>Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 19 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					

1918

CERTIFICATE OF DEATH

62-83

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London

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18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02488

02498

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Verma</b> Middle <b>Della</b> Last <b>Cannon</b>				4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 24, 1904</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.		11. IF UNDER 24 HRS. Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Operator-Employee Shirt Factory</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Somerset Co. Maryland</b>			
13. FATHER'S NAME <b>Hampton Greene</b>				14. MOTHER'S MAIDEN NAME <b>Verna Bloodsworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mr. Edward S. Cannon (Husband) 206 S. Naylor Street Salisbury, Maryland</b>			
17. INFORMANT <b>Mr. Edward S. Cannon (Husband) 206 S. Naylor Street Salisbury, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis and diabetes</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 29, 1962</b> to <b>Feb. 15, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 14, 1962</b> , and that death occurred at <b>4 A. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>				22b. DATE SIGNED <b>2/15/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>				22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 17, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 19 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>James E. K...</b>							

MEDICAL CERTIFICATION

15888

CERTIFICATE OF DEATH

20120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
e. COUNTY				e. STATE						
02499 Wicomico MARYLAND				02489 MARYLAND TALBOT						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
Salisbury, Maryland		6 days		EASTON, RURAL 20X-2						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Deer s Head State Hospital				R. F. D.						
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		Month		Day		Year	
First Middle Last			Herbert Chance		Feb.		11		19 62	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUGUST 16, 1888		73 yrs.		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
FARMER			RETIRED		TALBOT		U.S.A.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME							
CHARLES CHANCE			LAURA KANTZ							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address					
(If yes give war or dates of service)			215-38-0806		Mrs Elsie Chance. Easton Sud R.F.D.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 332X Recurrent cerebral thrombosis								6 hrs.		
DUE TO (b) Arteriosclerosis general								years		
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)		
19						Feb. 5, 1962		Feb. 11, 1962		
21. I certify that (I) (this hospital) attended the deceased from Feb. 5, 1962, to Feb. 11, 1962, that (I) (we) last saw the deceased alive on Feb. 11, 1962, and that death occurred at 2:00PM from the causes and on the date stated above.										
22a. SIGNATURE V. Juerman				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 11, 1962				
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.				22d. ADDRESS Salisbury, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
Burial		2-14-62		Woodlawn		Easton		md		
24. FUNERAL DIRECTOR'S SIGNATURE A. J. Hamilton				ADDRESS Harrison, St. Michael's		25a. REC'D BY REGISTRAR DATE FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House		



00199

02183

FASTON, RURAL  
R.F.D.

X

August 16, 1973

X

White

FARMER

Retired

TABOT

W.S.A.

CHARLES CHANCE

LAURA KANT

21-38-0000 Mrs. Elaine Chance

V. J. Furman

21-38-0000 Mrs. Elaine Chance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02490

02500

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>301 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown,</b>		14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>RD 2 - Fairlee</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Cleveland</b> Last <b>Coleman</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/18/1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Wells</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>?</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 10</b> , 19 <b>61</b> , to <b>Feb. 5</b> , 19 <b>62</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 5</b> , 19 <b>62</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>		22b. DATE SIGNED <b>2/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/8/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Rock Hall Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L Lane</b>		25a. REC'D BY REGISTRAR <b>FEB 13 62</b>	
25b. REGISTRAR'S SIGNATURE <b>Carroll S. Tinsdale</b>			

CERTIFICATE OF DEATH



John Charles  
11/11/1900



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02501						02491					
1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY in 1b <b>881 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grasonville</b> <b>17X-2</b>				d. STREET ADDRESS <b>--</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Thomas</b>			First <b>--</b> Middle <b>--</b> Last <b>COOPER</b>			4. DATE OF DEATH <b>February 5, 1962</b>			Month <b>February</b> Day <b>5</b> Year <b>1962</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 20, 1889</b> <b>72</b> yrs.		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Waterman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles H. Coorer</b>				14. MOTHER'S MAIDEN NAME <b>Rachel Hazelton</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>222-09-0350</b>				17. INFORMANT <b>James Cooper - Grasonville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>ease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 8, 1959</b> , to <b>Feb. 5, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5, 1962</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>V. Juerman</b>				M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/5/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>				22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-8-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Robinson Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Grasonville, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>James Seashell - Easton, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>James S. Thomas</b>			

No. \_\_\_\_\_  
Charles H. Cooke  
Packet Hazelton  
Liberator  
D. 24

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>21 hrs 35 min</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>32 GREENWAY AVENUE</u>	
3. NAME OF DECEASED (Type or print) <u>Barbara J. Custis</u>		4. DATE OF DEATH <u>February 1 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 24, 1919</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13. FATHER'S NAME <u>EDWARD JOLLY</u>		14. MOTHER'S MAIDEN NAME <u>MELVINA BOUILLOUX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>H. J. CUSTIS, JR.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Inferior mesenteric artery thrombosis</u> 416X DUE TO (b) <u>Rheumatic heart disease &amp; mural thrombus &amp; embolism to both legs:</u> DUE TO (c) <u>auricular fibrillation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>7 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William H. Fisher, Jr.</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER, JR.</u>		22d. ADDRESS <u>Salisbury Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		23d. LOCATION (City, town or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Watson</u>		25. REC'D BY REGISTRAR <u>FEB 5 '62</u>	
ADDRESS <u>POCOMOKE CITY, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>	

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Robert H. Watson, Baltimore City, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02493

02503

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 1</b>				d. STREET ADDRESS <b>R.D.# 1</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>HERBERT</b> Last <b>DARBY</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>3rd</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1893</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Joseph P. Darby</b>				14. MOTHER'S MAIDEN NAME <b>Ella Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Mrs. Nellie D. Darby (Wife)</b> Address <b>R.D.# 1 Hebron, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Thrombosis</b> DUE TO <b>Arteriosclerotic Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) <b>N/A</b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 5, 1962 to Feb 3, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb 2, 1962</b> and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>H.S. Kuhlman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 6 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. H.S. Kuhlman</b>				22d. ADDRESS <b>Sharptown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 6, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Gardens - Salisbury, Maryland</b>		23d. LOCATION (City, town, or county) <b></b> (State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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CERTIFICATE OF DEATH

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02494

02504

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>616 Liberty Street</b>				d. STREET ADDRESS <b>616 Liberty St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROFELDA ISABELLE DAVIS</b>				4. DATE OF DEATH Month Day Year <b>FEBRUARY 9th 1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 9, 1913</b>		9. AGE (In years last birthday) <b>48</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Nurse-Employed at Pen. Gen. Hosp</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Mardela, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Claude E. Russell</b>				14. MOTHER'S MAIDEN NAME <b>Cora E. Driscoll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mr. Russell S. Davis (Son)</b> Address <b>Babbitt Road Euclid 23, Ohio (Apt. D-2)</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331 X</b> DUE TO <b>Cerebro Vascular Accident</b>            Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. } DUE TO <b>Hypertension</b>            (b) _____ DUE TO _____            (c) _____</p> </div> <div style="width: 65%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
				20f. (City or town) <b>N/A</b> (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-6</b> 19 <b>61</b> to <b>2-9</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-5</b> 19 <b>62</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. C. Mitchell</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 10 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>				22d. ADDRESS <b>Maryland Ave., Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 12, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fruitland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Fruitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02505

## CERTIFICATE OF DEATH

02435

<b>1. PLACE OF DEATH</b> a. COUNTY: <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>SALISBURY</u> c. LENGTH OF STAY IN 1b: _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): <u>PENINSULA GENERAL Hospital</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE: <u>MARYLAND</u> <span style="float: right;">b. COUNTY: <u>Wicomico</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): <u>X POWELLVILLE</u> d. STREET ADDRESS: <u>R.D.# 1 Pittsville Route</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilbur John Davis</u>			<b>4. DATE OF DEATH</b> <u>February 21 1962</u>		Month Day Year February 21 1962				
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 22, 1901</u>			
<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer-(Road Construction)</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Powellville, Maryland</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>				
<b>13. FATHER'S NAME</b> <u>Jefferson Davis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Martha Perdue</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> _____					
<b>17. INFORMANT</b> <u>Mrs. Anna Mae Davis (Wife)</u> <u>R.D.#1 Pittsville</u> <u>Powellville, Maryland</u>				Address					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia and</u> <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Cerebral Thrombosis</u>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>2/14 1962</u> to <u>2/21 1962</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>2/20 1962</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Thomas C. Hill, Jr.</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Feb. 21, 1962</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Thomas C. Hill, Jr.</u>				<b>22d. ADDRESS</b> <u>Pine Bluff Road-Salisbury, Maryland</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 24, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Johns Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Bowellville, Maryland</u>			
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u> <u>SALISBURY, MARYLAND</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 26 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02506

02496

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>607 Hammond St</b>	
3. NAME OF DECEASED (Type or print) <b>LAURA JANE DENNIS</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>28</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <b>Aug. 17, 1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>11</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Lemual Clark</b>		14. MOTHER'S MAIDEN NAME <b>Leah R. Smack</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Orlie C. Dennis (Husband)</b>	
17. INFORMANT <b>Salisbury, Maryland</b>		Address <b>607 Hammond St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Heart Disease</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>1962</b> , that (I) (we) last saw the deceased alive on <b>28 Feb 1962</b> , and that death occurred at <b>8:45 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Earl L. Royer</b>		22b. DATE SIGNED <b>Mar. 2 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>		22d. ADDRESS <b>407 Camden Ave. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar. 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsonsbury Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Parsonsbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 5 '62</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02507

02497

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u></span> c. LENGTH OF STAY IN 1b <u>12</u> <u>SALISBURY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> <span style="float: right;">f. COUNTY <u>Wicomico</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> d. STREET ADDRESS <u>306 E. WILLIAM ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>HOMER LEE DISHARON</u>		<b>4. DATE OF DEATH</b> Month <u>FEBRUARY</u> Day <u>22</u> Year <u>1962</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept 3 1889</u> <b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MANAGER</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Mercantile</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>EMORY Disharoon</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH Shackley</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <u>WWII</u> <b>16. SOCIAL SECURITY NO.</b> <u>214-10-7734</u> <b>17. INFORMANT</b> <u>SALLIE E. Disharoon</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>strangulated</u> (c) <u>Immediately Postoperative - Repair Right Femoral Hernia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).</b> <u>strangulated</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at..... A.M., from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>David J. Gilmore</u> M.D.		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>2/24/62</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>David J. Gilmore</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>2/24/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>PARSONS Cemetery</u> <b>23d. LOCATION (City, town or county)</b> <u>LAUREL, Delaware</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harold P. Disharoon</u> <b>ADDRESS</b> <u>Laurel, Del.</u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles E. Hume</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02508						02498					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <u>Wicomico County</u> <u>MARYLAND</u>						a. STATE <u>Maryland</u> b. COUNTY <u>Kent County</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u> <u>1437-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>						d. STREET ADDRESS <u>102 Queen St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last <u>Benjamin Maitland DU BOIS</u>						Month Day Year <u>February 4, 19 62</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1882</u>		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pres. Coal Mining Co. (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edmund DuBois</u>						14. MOTHER'S MAIDEN NAME <u>Mary Maitland</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>295-09-7205</u>		17. INFORMANT <u>Page C. DuBois</u> Address <u>Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent cerebral thrombosis with left hemiplegia</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>	
DU TO (b) <u>Arteriosclerosis, general</u>										?	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
<u>Arteriosclerotic cardiovascular disease and aortic aneurysm</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1962</u> , to <u>Feb. 4, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 4, 1962</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>V. Juerman</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/5/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>						22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/6/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>near - Chestertown, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Caroline L. Hanks</u>			

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WILLIAM WALLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02509

CERTIFICATE OF DEATH

02499

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> <i>md</i> <i>MARYLAND</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b <i>yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>522 Elm St</i>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> d. STREET ADDRESS <i>522 Elm St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bronville D Sutton</i>												4. DATE OF DEATH Month Day Year <i>2 15 1962</i>																							
5. SEX <i>m</i>		6. COLOR OR RACE <i>e</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-21-900</i>				9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>						10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>						11. BIRTHPLACE (County & State, or foreign country) <i>Allen md</i>						12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>																	
13. FATHER'S NAME <i>Haley Wales</i>												14. MOTHER'S MAIDEN NAME <i>Sara Gunther</i>																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>												16. SOCIAL SECURITY NO. <i>?</i>												17. INFORMANT Address <i>Sara Gunther</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Calcular Rheumatic Heart Disease</i> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic Fever</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>1 1/2 yrs. Indefinite</i>												INTERVAL BETWEEN ONSET AND DEATH																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																							
21. I certify that (I) (this hospital) attended the deceased from <i>15 July 1960</i> to <i>15 Feb 1962</i> that (I) (we) last saw the deceased alive on <i>15 Feb 1962</i> and that death occurred at <i>2 AM</i> , from the causes and on the date stated above.																																			
22a. SIGNATURE <i>E. A. Purnell</i>												22b. DATE SIGNED <i>19 Feb 62</i>																							
22c. PHYSICIAN'S NAME (Type) <i>E. A. Purnell</i>												22d. ADDRESS <i>652 W. Main St, Salisbury, Md.</i>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>1-20-62</i>						23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres Cem</i>						23d. LOCATION (City, town or county) (State) <i>Salisbury md</i>																	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Dorothy M West</i>												24b. ADDRESS												25a. REC'D BY REGISTRAR <i>DATE FEB 23 '62</i>				25b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
02510														
02500														
1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>296 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline County</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b> d. STREET ADDRESS <b>Route 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>--</b> Last <b>ELIAS</b>					4. DATE OF DEATH Month <b>February</b> Day <b>8,</b> Year <b>1962</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR 9, 1884</b>		9. AGE (In years last birthday) <b>77</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAY LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CANNERY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>USA PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <b>unknown</b>					14. MOTHER'S MAIDEN NAME <b>unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>					16. SOCIAL SECURITY NO. <b>Dr. E. Paul Knott, Denton, Md.</b>					17. INFORMANT Address <b>Denton, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Periarthritis nodosa</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1961</b> to <b>Feb. 8, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 8, 1962</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above.														
22a. SIGNATURE <b>L. V. Maldve</b>					22b. DATE <b>2/9/62</b>		22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M.D.</b>							
22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>					22e. REC'D BY REGISTRAR DATE <b>FEB 14 '62</b>									
22f. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>					22g. REGISTRAR'S NAME <b>Arthur L. Hanna</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Feb. 12, 1962</b>					23b. DATE THEREOF <b>Feb. 12, 1962</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>				
23d. LOCATION (City, town or county) <b>Denton</b>					23e. LOCATION (State) <b>Md.</b>					23f. LOCATION (Country) <b>USA</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Moore</b>					24a. ADDRESS <b>Denton, Md.</b>					24b. DATE <b>FEB 14 '62</b>				
24c. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>					24d. REGISTRAR'S NAME <b>Arthur L. Hanna</b>					24e. REGISTRAR'S ADDRESS <b>Denton, Md.</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02511

02501

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury West Ocean City</u> d. STREET ADDRESS <u>Peninsula General Hospital</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EVANS</u>				<b>4. DATE OF DEATH</b> <u>FEBRUARY 22 1962</u>			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>NEGRO</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEBRUARY 20 1962</u>	
<b>9. AGE</b> (In years last birthday) <u>2</u>		<b>IF UNDER 1 YEAR</b> Months <u>2</u> Days <u>2</u>		<b>IF UNDER 24 HRS.</b> Hours <u>2</u> Min. <u>2</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John Mack Bailey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Evans</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Gertrude Evans West Ocean City Md.</u>			
<b>17. INFORMANT</b> <u>Gertrude Evans</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Immaturity - 780 gm</u> DUE TO (c) <u>Prematurity -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/20</u> , 19 <u>62</u> , <b>19</b> , that (I) (we) last saw the deceased alive on <u>2/22</u> , 19 <u>62</u> , and that death occurred at <u>9:45</u> A.M., from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>William C. Morgan</u>				<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type)				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Feb. 26, 1962</u>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bevins Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) <u>Fruitland</u> (State) <u>Md</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Clinton F. Stewart</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Arthur E. Kline</u>			
<b>25b. REGISTRAR'S SIGNATURE</b>				<b>25c. DATE</b> <u>MAR 5 '62</u>			

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Garrett Avenue

John Mack Bailey

April 1, 1965, Bayview Cemetery, Cleveland, Ohio

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02512

## CERTIFICATE OF DEATH

02502

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>			
c. LENGTH OF STAY IN 1b <u>10 days</u>				d. STREET ADDRESS <u>Lawsonia Section</u>			
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Olin ALONZA EVANS</u>				4. DATE OF DEATH <u>February 11 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canvas Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sails &amp; Awnings</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Crisfield, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Severn A. Evans</u>				14. MOTHER'S MAIDEN NAME <u>Erianna Holland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Kathryn Myers--Salisbury, Md.</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal shut down (Complete)</u> 446X DUE TO (b) <u>Chronic nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-62</u> to <u>2-11-62</u> , that (I) (we) last saw the deceased alive on <u>2-11-62</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Currie Hearn</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>				22d. ADDRESS <u>226 W. Main St. Salisbury</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 14, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>R.F.D. Crisfield, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw &amp; Sons--Crisfield, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Secretary

My Dear

Dear Sir

10 days

Enclosed

Remittance

June 15, 1939

U.S.A.

Chicago, Ill.

Wells & Wells

General

Chicago, Ill.

General A. Evans

Mr. Evans, Chicago, Ill.

Dear Mr. Evans:

Enclosed

Very truly yours,

W. L. A. Chicago, Ill.

General

Lab. 1002

Chicago, Ill.

Chicago & Evans, Chicago, Ill.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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02503

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury, Maryland</b> c. LENGTH OF STAY IN lb <b>2mo. 21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> d. STREET ADDRESS <b>Box 94 Route 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ernest Floyd</b>		4. DATE OF DEATH <b>Feb. 18 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 3, 1890</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WESTOVER SOMERSET</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Floyd</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA Adams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>213-03-4583</b>	
17. INFORMANT <b>WALTER Floyd</b>		Address <b>Crisfield Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 28</b> , 19 <b>61</b> to <b>Feb. 18</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb. 18</b> , 19 <b>62</b> , and that death occurred at <b>8:50AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE SIGNED <b>Feb. 18, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Feb. 21, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOPEWELL</b>		23d. LOCATION (City, town or county) (State) <b>HOPEWELL MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Anthony E. Ward</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>	
ADDRESS <b>Crisfield Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	

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John X. Henry

John X. Henry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MAYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02514

## CERTIFICATE OF DEATH

02504

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Tony Tank</u>	
3. NAME OF DECEASED (Type or print) <u>MARY (Marie)</u> First <u>Isabelle</u> Middle <u>Gassaway</u> Last		4. DATE OF DEATH <u>February 25</u> 19 <u>62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Martha Fields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or date of service)		17. INFORMANT <u>Mr. Clarence S. Gassaway (Husband) Tony Tank</u> Address <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from Stomach</u> DUE TO (b) <u>Pendomucinous Cystadenocarcinoma</u> DUE TO (c) <u>of the Ovary with Metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>N/A</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	20f. (City or town) <u>N/A</u> (County) <u>N/A</u> (State) <u>N/A</u>
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25, 1962</u> to <u>Feb. 25, 1962</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Feb. 25, 1962</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul G. Cayaves</u> M.D.		22b. DATE SIGNED <u>2-25-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES</u>		22d. ADDRESS <u>222 N. Division St. Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 28, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shad Point Cemetery - R.D. # Salisbury, Maryland</u>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>MAR 2 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

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(Part 1)



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PAUL G. CAYAN  
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HOLWAY & COMPANY, SELLERS, MANHATTAN, N.Y.  
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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
02515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02505

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. - Pen. Gen Hospital</b>			d. STREET ADDRESS <b>225 Newton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>RAYMOND JEFFERSON GUTHRIE</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>3rd</b> Year <b>19 62</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1897</b>		9. AGE (In years last birthday) <b>64</b> yrs. <b>4</b> Months <b>18</b> Days <b>18</b> Hours <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant at Service Station</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
13. FATHER'S NAME <b>Benjamin James Guthrie</b>			14. MOTHER'S MAIDEN NAME <b>Sally Mary Coulbourne</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Benjamin J. Guthrie (Son) 7052 Floyd Ave. Springfield, Virginia (FI-4-6412)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Feb. 5 / 1962</b>	
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 6, 1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>Feb 6 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02516

02506

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>210 Lincoln Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>ELMER Bradley Hammond</u>				4. DATE OF DEATH <u>February 4, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR <u>4</u> Months <u>9</u> Days		IF UNDER 24 HRS. <u>19</u> Hrs. <u>62</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee-W.F.Allen Co.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Wicomico Co. Maryland</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U S A</u>			
13. FATHER'S NAME <u>Quinton Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Parker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>Mr Bradley D. Hammond (Grand-Son) 500 Woodcrest Ave. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442 X DUE TO (b) <u>Atherosclerotic C-V-R Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Septic Shock</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/19, 1962</u> to <u>2/4, 1962</u> ; that (I) (we) last saw the deceased alive on <u>2/4, 1962</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>William D. Gray</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 4th/1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>				22d. ADDRESS <u>Camden Ave. Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 7, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hammond Family Cemetery-R.D.#</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOILWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>FEB 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
02517					02507									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23x-2									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>					d. STREET ADDRESS <u>23x-2</u>									
3. NAME OF DECEASED (Type or print) <u>Florence</u> <u>B</u> <u>Hartman</u>					4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1962</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> <u>Married</u> <input type="checkbox"/> <u>Widowed</u> <input type="checkbox"/> <u>Divorced</u>		8. DATE OF BIRTH <u>Nov. 1 - 1872</u>		9. AGE (In years last birthday) <u>89/3/10</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY						
13. FATHER'S NAME <u>Edwin Jones</u>					14. MOTHER'S MAIDEN NAME <u>Marilla Frost</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>None</u>					17. INFORMANT <u>Mrs. Julia H. Shaddy, Snow Hill, md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422-1 DUE TO (b) <u>Arteriosclerosis general</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Residual right hemiparesis due to old cerebral thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>11</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 11, 1957</u> to <u>Feb. 11, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 11, 1962</u> , and that death occurred at <u>8:40 AM</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>V. Juerman</u>					22b. DATE SIGNED <u>Feb. 11, 1962</u>									
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>					22d. ADDRESS <u>Salisbury, Maryland</u>									
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial Feb. 13/62</u>					23b. DATE THEREOF <u>Feb. 13/62</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Quaker Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Snow Hill md</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maye Dennis</u>					25. REC'D BY REGISTRAR <u>Feb. 13 '62</u>									
25a. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					25b. REGISTRAR'S SIGNATURE									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02508

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>203 New York Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>ANNIE E</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>21</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1893</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pocomoke, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Henry Thomas Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Martha Emma Lankford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. INFORMANT <b>Mr. Hollie W. Hastings (Husband)</b>		Address <b>203 New York Avenue - Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Acidosis</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Diabetes Mellitus</b> (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Coronary artery arteriosclerosis with myocardial infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>N/A</b> 19 <b>19</b> p.m. <b>N/A</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1962</b> to <b>Feb 1962</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>21 Feb 1962</b> , and that death occurred at <b>12:15 P M</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Fitzgerald</b>		22b. DATE SIGNED <b>Feb. 23/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Fitzgerald</b>		22d. ADDRESS <b>Pine Bluff Road - Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 23, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 26 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			







12  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02509

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY in 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martha J Hastings</b>				4. DATE OF DEATH Month Day Year <b>2-2-62 19</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-1882</b>	9. AGE (In years last birthday) <b>79</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOSEPH T. BRITTINGHAM</b>				14. MOTHER'S MAIDEN NAME <b>RHODA ROUNDS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS. DANIEL J. PARKER, PARSONSBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>4 2 0.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arterio-sclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Hours  Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl I. Royer</b> EXAMINER'S NAME (Type)				DATE SIGNED <b>2-3-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>2/4/1962</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park Salisbury, MD</b>				22d. LOCATION (City, town, or country) (State) <b>Salisbury, MD</b>			
23. FUNERAL DIRECTOR ADDRESS <b>Hill &amp; Johnson Co, Salisbury, MD</b>				24a. REC'D BY REGISTRAR <b>FEB 6 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

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*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02520

## CERTIFICATE OF DEATH

Item 9 Film G308 3/13/62 iwk

03915

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>135 Washington Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Virginia</b> Last <b>Henson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1887</b>
9. AGE (In years last birthday) <b>74 2/3</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Travis</b>		14. MOTHER'S MAIDEN NAME <b>? not known</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Alice Atkins</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, general</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Ca. of esophagus with metastases.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>11</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 26</b> ....., 19 <b>56</b> , to <b>Feb. 27</b> ....., 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>Feb. 27</b> ....., 19 <b>62</b> , and that death occurred at <b>9:35 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>V. Juerman</b>		22b. DATE SIGNED <b>2/27/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Mar 4, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Waukeem</b>	23d. LOCATION (City, town or county) (State) <b>Cambridge Dorch. Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Barker M. West</b>		25a. REC'D BY REGISTRAR <b>MAR 9 '62</b>	
ADDRESS <b>Salisbury Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>	

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

02521

02510

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 76 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 601 Camden Ave				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury d. STREET ADDRESS 1 601 Camden Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First COLLIER Middle HILL Last		4. DATE OF DEATH Month February Day 25 Year 19 62					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1886	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George C. Hill		14. MOTHER'S MAIDEN NAME Mary Mc Grath					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Clara McGrath Hill, Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X DUE TO Secondary hemorrhages shock (b) Carcinoma of rectum (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 6 mo 1 1/2 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 1:14 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Green H. Fisher, Jr. M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) William H. Fisher, Jr. M.D.		22d. ADDRESS MEDICAL CENTER, SALISBURY, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 27, 1962		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			
23d. LOCATION (City, town, or county) Salisbury, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 2 '62			
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

George C. Hill

(M)

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CERTIFICATE OF DEATH

05210

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C H I L D R E N

W A D E

11/11

11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02522

02511

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Rt. 4, Mt. Herman, Md.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>William</b> Middle <b>Philip</b> Last <b>Joseph Hotton</b>		<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>27</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Dec. 21, 1873</b>
<b>9. AGE</b> (In years last birthday) <b>88</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>6</b>	
<b>IF UNDER 24 HRS.</b> Hours <b>2</b> Min. <b>6</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer-Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Guersney Islands-England</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>ENGLAND</b>	
<b>13. FATHER'S NAME</b> <b>Nicholas Hotton</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ann Carroll</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mrs. Henrietta E. Hotton (Wife) R.D. #4 (Mt. Hermon) Salisbury, Maryland</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of left hip</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from Jan. 22, 1962, to Feb. 27, 1962, that (I) (we) last saw the deceased alive on Feb. 26, 1962, and that death occurred at 6:30 A.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Lee L. Lawry</b> M.D.		<b>22b. DATE SIGNED</b> <b>2/27/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Lee L. Lawry, M.D.</b>		<b>22d. ADDRESS</b> <b>Deer's Head Hospital; Salisbury, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Mar. 1, 1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parsons Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Salisbury, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOLLOWAY &amp; COMPANY</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAR 5 '62</b>	
<b>ADDRESS</b> <b>SALISBURY, MARYLAND</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>	

11:50

STATE OF TEXAS

11:50

*Copy*

*Chas. H. ...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02523

## CERTIFICATE OF DEATH

02512

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Shoptown</i> c. LENGTH OF STAY IN 1b <i>40</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Shoptown</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <i>James</i> Middle <i>Jenkins</i> Last <i>Jenkins</i>				<b>4. DATE OF DEATH</b> Month <i>Feb</i> Day <i>22</i> Year <i>1962</i>			
<b>5. SEX</b> <i>male</i>		<b>6. COLOR OR RACE</b> <i>W</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>7-21-1900</i>	
<b>9. AGE</b> (In years last birthday) <i>61</i> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Labor</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>none</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>S Carolina</i>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A</i>							
<b>13. FATHER'S NAME</b> <i>James Jenkins</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Christine Walker</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____				<b>16. SOCIAL SECURITY NO.</b> <i>130-01-8110</i>		<b>17. INFORMANT</b> <i>Martha Jenkins</i> Address _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>uterus clotted heart</i> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (b) <i>Bronchial Asthma</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____							
<b>20c. TIME OF INJURY</b> Hour _____ e.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Feb 19</i> , 19 <i>62</i> <b>to</b> <i>Feb 21</i> , 19 <i>62</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Feb 20</i> , 19 <i>62</i> , <b>and that death occurred at</b> <i>2A</i> M., <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>A. S. Kuhlman</i>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> _____	
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>A. S. Kuhlman</i>				<b>22d. ADDRESS</b> _____			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>2-26-62</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Shoptown Cem</i>		<b>23d. LOCATION</b> (City, town or county) <i>Wicomico</i> (State) <i>md</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Booker M. West</i>				<b>ADDRESS</b> _____		<b>25a. REC'D BY REGISTRAR</b> <i>5 '62</i>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles E. Hume</i>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02524

## CERTIFICATE OF DEATH

02513

Item 9 Film G308 3/1/62 ink

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>13 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jersey Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Wicomico</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u> d. STREET ADDRESS <u>1 Jersey Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Thornton B. Jolley</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> - Day <u>27</u> Year <u>1962</u>		<b>9. AGE</b> (In years last birthday) <u>45 4/4</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.			
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Col</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-15-1916</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Mortician</u> <b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>		<b>13. FATHER'S NAME</b> <u>Fulton Jolley</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Ada G. Burnett</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WW II</u> <b>16. SOCIAL SECURITY NO.</b> <u>164-16-7573</u> <b>17. INFORMANT</b> <u>Mrs. Loretta Jolley, Salisbury, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>Hypertension</u> (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>31 Dec 61</u> , 19 <u>61</u> , to <u>27 Feb</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>27 Feb</u> , 19 <u>62</u> , and that death occurred at <u>1P</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>EA Purvell</u>		<b>22b. DATE SIGNED</b> <u>27 Feb 62</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>EA PURVELL</u>			
<b>22d. ADDRESS</b> <u>Salisbury, Md.</u>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>2-27-62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Green Acre</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Salisbury Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James H. Ashwell, Easton, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
02525  
02514  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Spring Hill Private Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>ALBERT</b> Middle <b>KENNEY</b> Last <b>KENNY Sr.</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1962</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1870</b>	9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Grocer, Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Edward Kenney</b>				14. MOTHER'S MAIDEN NAME <b>Maria Ellen Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-7020</b>		17. INFORMANT Address <b>Mrs. C. Maurice Adkins, 619 Pinehurst Ave, Salis</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Cornary thrombosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1961</b> to <b>2-11 1962</b> that (I) (we) last saw the deceased alive on <b>2-2 1962</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip A. Insley</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Philip A. Insley, M.D.</b>				22d. ADDRESS <b>W. Main St. Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 13, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co., Salisbury, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

0511

DECLARATION OF DEATH

0511

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02526

02515

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico County</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>29 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>James</b> Last <b>KENNEY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1880</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Kenney</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ellis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-01-5257</b>	
17. INFORMANT <b>Ethan Kenney, Delmar, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.1 Intestinal Obstruction, partial</b> DUE TO <b>Adhesional Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>5 yrs</b> DUE TO (c) <b>2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16, 1962</b> to <b>2/14/1962</b> , that (I) (we) lost saw the deceased <b>live on Feb. 14, 1962</b> , and that death occurred at <b>4:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE <b>2/14/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-17-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ralph Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Delmar, Del. RFD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.S. Marvel</b>		25a. REC'D BY REGISTRAR <b>Co. Delmar, Del.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		25c. DATE <b>FEB 16 '62</b>	

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CERTIFICATE OF DEATH

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MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON  
JANUARY 1915  
DEATH OF  
MRS. J. M. BROWN  
AGE 65  
RESIDENCE 123 MAIN ST. BOSTON  
CAUSE OF DEATH  
HEART DISEASE  
CERTIFICATE OF DEATH  
JANUARY 1915  
J. M. BROWN  
123 MAIN ST. BOSTON  
HEART DISEASE  
JANUARY 1915

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02527

## CERTIFICATE OF DEATH

02516

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORIOLE</u> d. STREET ADDRESS <u>19X-2</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAISEY E KRICK</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 26, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 21, 1884</u>	
9. AGE (In years, last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Williamport Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Not known</u>				14. MOTHER'S MAIDEN NAME <u>Emma Kauffman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-03-0177</u>			
17. INFORMANT <u>Mrs Jean Johnson Westover</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction due to</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>May 1960</u> to <u>Feb 26, 1962</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Feb 26, 1962</u> , and that death occurred at <u>9:58</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas C. Helge, M.D.</u>				22b. DATE SIGNED <u>2/26/62</u>		22c. PHYSICIAN'S NAME (Type) <u>Pine Bluff Rd., Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-1-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery, Oriole, Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levin Wilson Prince</u>				25a. REC'D BY REGISTRAR <u>MAR 5 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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Handwritten notes and signatures, including "C. H. 2-1-62" and "C. H. 2-1-62".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02528

## CERTIFICATE OF DEATH

02517

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> 12			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>205 S. NAYLOR ST</u>			
3. NAME OF DECEASED (Type or print) <u>MARTHA Emily Lemon</u>				4. DATE OF DEATH <u>February 23, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22, 1873</u>	
9. AGE (in years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				13. FATHER'S NAME <u>Charles Sturgis</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Parsons</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)			
16. SOCIAL SECURITY NO. <u>334X</u>				17. INFORMANT <u>Mrs. Bertha M. Adkins (Daughter)</u> Address <u>205 S. Naylor Street Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Uremia</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Kidney Failure</u> (c) <u>Stroke</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>N/A</u> p.m. <u>N/A</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>		20f. (City or town) (County) (State) <u>N/A</u>	
21. I certify that (1) (this hospital) attended the deceased from <u>2-14, 1962</u> to <u>2-23, 1962</u> , that (2) (we) last saw the deceased alive on <u>2-23, 1962</u> , and that death occurred at <u>4:27 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. B. Smith</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 26, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>MAR 2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND-STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02529

02518

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b. <u>12</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>211X Naylor St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William Johnson Lilley</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>8</u> Year <u>1962</u>		<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 13, 1909</u>		<b>9. AGE</b> (In years last birthday) <u>52</u> yrs. <u>5</u> Months <u>25</u> Days <u>8</u> Hours <u>0</u> Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Employee-Newspaper Co. (Mat. Manager)</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Dover, Delaware</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U S A</u>					
<b>13. FATHER'S NAME</b> <u>Charles S. Lilley</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary A. Johnson</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>N/A</u>				<b>17. INFORMANT</b> <u>Mrs. Margaret Lilley (Wife)</u> Address <u>211 Naylor St Salisbury, Maryland</u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary thrombosis</u> (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>N/A</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 hrs</u> <u>3 hrs.</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)												<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>N/A</u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>				<b>20f. (City or town)</b> <u>Salisbury</u> (County) <u>N/A</u> (State) <u>N/A</u>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 8, 1962</u> <b>to</b> <u>Feb 8, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 8, 1962</u> , <b>and that death occurred at</b> <u>8:00 AM</u> , <b>from the causes and on the date stated above.</b>																							
<b>22a. SIGNATURE</b> <u>Dr. Earl M. Beardsley</u>												<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b> <u>2/8/62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Earl M. Beardsley</u>												<b>22d. ADDRESS</b> <u>MD. Ave. Salisbury, Maryland</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Feb. 10, 1962</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Spring Hill Memory Gardens- Salisbury, Maryland</u>				<b>23d. LOCATION</b> (City, town or county) (State)											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>												<b>ADDRESS</b> <u>SALISBURY, MARYLAND</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 9 '62</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kinne</u>			

05253

05253

(M)

William Henry Miller

Proprietor of the  
Columbia Pharmacy

Wm. H. Miller

HOLLWAY & COMPANY, BALTIMORE, MARYLAND

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02530

02519

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>806 East Church St</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN FRANK LONG SR.</b>				4. DATE OF DEATH <b>FEBRUARY 6 19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April. 13-1881</b>	
9. AGE (In years last birthday) <b>80</b>		10. IF UNDER 1 YEAR <b>7</b> Months <b>23</b> Days		11. IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Conductor (Employee)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oak City, North Carolina</b>			
11. BIRTHPLACE (State or foreign country) <b>U S A</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Joseph John Long</b>				14. MOTHER'S MAIDEN NAME <b>Martha Dora House</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Address Mrs. Mary Anna Parker Long (Wife) 806 East Church St Salisbury, Maryland</b>			
17. INFORMANT <b>Address Mrs. Mary Anna Parker Long (Wife) 806 East Church St Salisbury, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. <b>Interventive Sclerotic Arterial Disease</b> DUE TO <b>year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET OF DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>N/A</b> 19 p. m. <b>N/A</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>				20f. (City or town) <b>N/A</b> (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9-9</b> 19 <b>62</b> to <b>2-6</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1-18</b> 19 <b>62</b> , and that death occurred at <b>3:00</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Earl L. Royer</b>				22b. DATE SIGNED <b>Feb. 1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Royer</b>				22d. ADDRESS <b>407 Camden Ave. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 8, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 8 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				25c. REGISTRAR'S SIGNATURE			

02513

STATE OF OHIO  
DEPARTMENT OF HEALTH

02530

Name of Patient		Date of Birth		Sex	
John Doe		1900		Male	
Address		City		County	
123 Main St		Columbus		Franklin	
Occupation		Education		Religion	
Teacher		High School		Catholic	
Marital Status		Previous Illnesses		Present Illness	
Single		None		Cough, Fever	
Date of Admission		Date of Discharge		Physician's Name	
10/1/20		10/15/20		Dr. Smith	
Signature of Patient		Signature of Physician		Hospital Name	
John Doe		Dr. Smith		St. Mary's	
Date of Signature		Date of Signature		Hospital Address	
10/1/20		10/15/20		123 Main St	
Patient's Signature		Physician's Signature		Hospital Seal	
John Doe		Dr. Smith		[Seal]	
Date of Signature		Date of Signature		Hospital Name	
10/1/20		10/15/20		St. Mary's	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

02531 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02520

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b M		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Fruitland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Morris St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wrightson		First Middle Last Marshall		4. DATE OF DEATH Month Day Year 2-2-62 19	
5. SEX M	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1900 61 yrs.		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Packing Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Asbury Marshall		14. MOTHER'S MAIDEN NAME Emily Corbin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Lelia Marshall New Church, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage - spontaneous 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardio-vascular disease (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Hours Years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 407 Camden Ave. Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-4-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-6-62		22c. NAME OF CEMETERY OR CREMATORY Hall's Hill Cem.	
23. FUNERAL DIRECTOR Samuel Savage		ADDRESS New Church, Va.		24a. REC'D BY REGISTRAR DATE FEB 9 '62	
				24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

MEDICAL CERTIFICATION

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Ernst

Haden M. Jones A

I. W. W. 11297

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>02532</b> <b>WICOMICO</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		c. LENGTH OF STAY IN 1b <b>19X-2</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, indicate before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> ✓		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRETTA Belle MARTIN</b>		4. DATE OF DEATH Month Day Year <b>February 25 1962</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 10 1981</b>		9. AGE (In years last birthday) <b>50</b> yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Clarence Barnes Princess Anne</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>560.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Shock, Hemorrhage from Hiatus Hernia</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21. I certify that (I) (the hospital) attended the deceased from <b>10/29 1960</b> to <b>2/25 1962</b> , that (I) (we) last saw the deceased alive on <b>2/25 1962</b> , and that death occurred at <b>PM</b> , from the causes and on the date stated above.		22. SIGNATURE <b>Thomas C. Hef, Jr.</b> M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/28/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews</b>		23d. LOCATION (City, town or county) (State) <b>Princess Anne Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>James Hannon Princess Anne Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 2 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hannon</b>	

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(M)

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(C)

Housewife

Housewife

(1)

Mr. Clarence Barnes

Journal 2/25/50 St. Andrews, Prince Edward Island

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

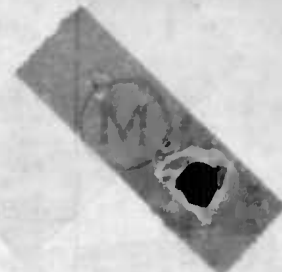
02522

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>025333</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Since 6/16/61</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pine Bluff State Hospital</b>				d. STREET ADDRESS <b>Chesapeake Pacific Avenue, Heights</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lemuel Reed Mason</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 23, 1877</b>	
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b>		IF UNDER 24 HRS. Hours <b>84</b> Min. <b>84</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bloxom, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Major Mason</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Clayton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>--</b>			
17. INFORMANT <b>Records of Pine Bluff State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Emphysema</b> DUE TO causing the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 16, 1961</b> to <b>Feb. 4, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 4, 1962</b> , and that death occurred at <b>4:10p</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>E. P. Ritchings</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Salisbury, Maryland</b>		22b. DATE SIGNED <b>2/5/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/6/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkside Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Parkside, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Henry M. Johnson</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Nov 1, 1947

Housewife Own Home Pound Va

Joe Kibara Emily Robinson

Max Forward Taylor Beach Mo

Quaker 2/1/47 Sunset Memorial Beach Mo

Quaker 2/1/47 Sunset Memorial Beach Mo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02535

02524

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Mardela (Rural)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>				d. STREET ADDRESS <b>1 R.D.# (Athol)</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>DELLA</b> Middle <b>FRANCES</b> Last <b>MILLS</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>August 5, 1865</b>	
9. AGE (In years last birthday) <b>96</b> yrs.		IF UNDER 1 YEAR Months <b>96</b> Days <b>96</b> Hours <b>96</b> Min.		IF UNDER 24 HRS. Months <b>96</b> Days <b>96</b> Hours <b>96</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Mister Hurley</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta White</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>		17. INFORMANT <b>Mrs. Gillis A. Mills (Daughter-In-Law)</b> <b>815 Filmore St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Cerebrovascular Accident</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b> <b>1 week.</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m. <b>N/A</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>				20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 7, 1962</b> to <b>Feb. 12 1962</b> that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <b>Feb. 12, 1962</b> , and that death occurred at <b>3:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Paul G. Cayaves</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>Feb. 14, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Paul G. Cayaves</b>				22d. ADDRESS <b>N. Division St. Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 14, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>				ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 14 '62</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury		c. LENGTH OF STAY IN 1b 1Yr. 10Mos. 2Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cambridge		0913-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Deer's Head State Hospital		d. STREET ADDRESS		12 Pine Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Flora		Middle -----		Last Mooney		4. DATE OF DEATH		Month February 17 Day 17 Year 19 62	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1878		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Unk.		10b. KIND OF BUSINESS OR INDUSTRY		Unk.		11. BIRTHPLACE (County & State, or foreign country)		Cambridge, Md.	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME		Matthews Pinder		14. MOTHER'S MAIDEN NAME		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO.		None		17. INFORMANT		Hospital Records --- Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		322 X DUE TO		Central Thrombosis		INTERVAL BETWEEN ONSET AND DEATH		1 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		Generalized Arteriosclerosis		(c)		5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/20/60, 19....., to 2/17/62, 19....., that (I) (we) last saw the deceased alive on 2/17/62, 19....., and that death occurred at 2:15 M. from the causes and on the date stated above.		22a. SIGNATURE Lee L. Lawry		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		20a. M. 7/20A.M.		22b. DATE SIGNED 2/17/62	
22c. PHYSICIAN'S NAME (Type)		Lee L. Lawry, M.D.		22d. ADDRESS		Deer's Head State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		2/20/1962		23c. NAME OF CEMETERY OR CREMATORY		Bethel Cemetery	
23d. LOCATION (City, town or county)		Cambridge, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE		Herbert St. Clair		ADDRESS		Cambridge, Md.		25a. REC'D BY REGISTRAR DATE FEB 20 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CERTIFICATE OF DEATH

<div>02537</div> <div>02526</div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XTASKIN (Rural)</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>GEORGE H. MOORE</u>						<b>4. DATE OF DEATH</b> <u>FEBRUARY 26, 1962</u>											
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/19/1882</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Owner &amp; Operator</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>							
<b>13. FATHER'S NAME</b> <u>George W. Moore</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Cristanna Wainwright</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> <u>Audrey Moore, Taskin, Md.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Brucella pneumonia</u> (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis - Atherosclerotic heart disease</u>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>						
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Jan 2-26, 1962</u> to <u>2-26, 1962</u> , that (I) (we) last saw the deceased alive on <u>2-26, 1962</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Philip A. Tasky</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2-28-62</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Philip A. Tasky</u>						<b>22d. ADDRESS</b> <u>Salisbury, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/28/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Taskin Cem.</u>		<b>23d. LOCATION</b> (City, town or county) <u>Taskin, Md.</u> (State)											
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>C. J. Wessely, Biville, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 7 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>									

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Lithium" and "chloride" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 12  
FOR STATE  
HEALTH DEPT.

02538

02527

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>12</u> <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>George</u> <u>Rollie</u> <u>Morris</u>			4. DATE OF DEATH <u>2-8-62</u> <u>19</u>		
5. SEX <u>M</u> <u>W</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1936</u>	9. AGE (In years last birthday) <u>25</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Mfg.</u>	11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Robert Morris</u>			14. MOTHER'S MAIDEN NAME <u>Louise Barnes</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-34-7902</u>	17. INFORMANT <u>Geo. Robert Morris, Delmar, Md.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of heart.</u>					<u>Sudden</u>
981X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by wife during domestic quarrel.</u>		
20c. TIME OF INJURY Month, Day, Year <u>7:35 P.M.</u> <u>2-8-62</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home.</u>	20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>2-11-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons</u>	22d. LOCATION (City, town, or country) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR <u>W.S. Marvel Co. Delmar, Del.</u>			24a. REC'D BY REGISTRAR <u>FEB 14 '62</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

US 283

2838



*[Handwritten signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02539

## CERTIFICATE OF DEATH

02528

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>R.</b> Last <b>Mowbray</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1894</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Reeves</b>		14. MOTHER'S MAIDEN NAME <b>Anna Lowe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-12-0154</b>	
17. INFORMANT <b>Hospital Records -- Salisbury, Maryland</b>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive - AS CVD</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/10/61</b> , 19____, to <b>2/13/62</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/13/62</b> , 19____, and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE SIGNED <b>February 13, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital - Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1/14/62</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>E. New Market Cem.</b>		23d. LOCATION (City, town or county) (State) <b>E. New Market, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Starving to Release - Federalsburg, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Hines</b>			

RECEIVED

FEB 28 1962

DEER'S HEAD  
STATE HOSPITAL

REC-11-033

*Handwritten notes and signatures at the bottom of the page, including "J. J. [illegible]" and "J. J. [illegible]"*



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02540  
CERTIFICATE OF DEATH  
02529

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b 2 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY d. STREET ADDRESS 412 COLE CIRCLE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) MARGARET CATHERINE First Middle Last		4. DATE OF DEATH FEBRUARY 24 1962 Month Day Year		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-11-20 Yrs. Months Days Hours Min.		9. AGE (In years last birthday) 41 yrs. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY Stint Factory		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Percy Nutter				14. MOTHER'S MAIDEN NAME Meta Parks				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 220-03-0152 Harry Muir Salisbury, Md.				16. SOCIAL SECURITY NO. 220-03-0152				17. INFORMANT Address Harry Muir Salisbury, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal Septicemia 692.5 DUE TO Probable Brain Abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetic Acidosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (Partial)														INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1962, to Feb. 24, 1962, that (I) (we) last saw the deceased alive on Feb. 24, 1962, and that death occurred at 3:30 P.M. from the causes and on the date stated above.																					
22a. SIGNATURE Thomas C. Hill, M.D.										22b. DATE SIGNED 2/25/62				22c. PHYSICIAN'S NAME (Type) Pine Bluff Road, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2-28-62				23c. NAME OF CEMETERY OR CREMATORY Oriole Cemetery				23d. LOCATION (City, town or county) Oriole, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE Lewis Wilson Princes										25a. REC'D BY REGISTRAR DATE MAR 5 '62				25b. REGISTRAR'S SIGNATURE Arthur S. House							

02520

02520

02520

(M)

(13)

11-11-24

Early Winter Still frosty  
Mete Park

22-03-11-11-24

Early 2-11-24  
Mete Park

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02541					02530									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Wicomico			a. STATE		Maryland							
		MARYLAND			b. COUNTY		Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Salisbury			170 days		12 Salisbury									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
Deer's Head State Hospital					117 Johnson Drive									
3. NAME OF DECEASED					4. DATE OF DEATH									
(Type or print)		First	Middle	Last	Month		Day		Year					
		Rose	Mary	Newell	Feb.		8		19 62					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		March 14, 1886		75 yrs.						
								IF UNDER 1 YEAR Months Days Hours Min.						
								10 24						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
House Work					None		Vermont		U S A					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Olin N. Renfrew					Mary A. Welton									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT				
No										Mr. Olin Charles Newell (Son) 117 Johnson Dr Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										24 hours				
420.1 DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Hypertensive arteriosclerotic cardiovascular disease				
DUE TO (b)										Years				
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY										20d. INJURY OCCURRED				
Month, Day, Year										While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
Hour e.m. p.m.										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
19										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Aug. 22, 1961, to Feb. 8, 1962, that (I) (we) last saw the deceased alive on Feb. 8, 1962, and that death occurred at 9 P.M. from the causes and on the date stated above.														
22a. SIGNATURE										22b. DATE SIGNED				
N. Maldve, M.D.										2/9/62				
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS				
L. V. Maldve, M. D.										Deer's Head State Hospital; Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF				
Burial										Feb. 11, 1962				
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town or county) (State)				
Mardela Mem. Cemetery-(New)										Mardela, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR				
HOLLOWAY & COMPANY SALISBURY, MARYLAND										25b. REGISTRAR'S SIGNATURE				
DATE FEB 13 '62										Arthur L. Hume				

05230

15230



WILLIAMS & COMPANY, SULLY, KENTLAND  
J. J. JONES, SULLY, KENTLAND  
J. J. JONES, SULLY, KENTLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02542						02531					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY <i>Wicomico</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			e. STATE <i>Maryland</i>			b. COUNTY <i>Wicomico</i>		
c. LENGTH OF STAY IN 1b <i>12</i>			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			d. STREET ADDRESS <i>103 New York Ave.</i>		
3. NAME OF DECEASED (Type or print) <i>WALTER MILTON NEWKIRK</i>			4. DATE OF DEATH <i>February 6 1962</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 8, 1883</i>		9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>28</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman- Toledo Scale Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>		11. BIRTHPLACE (County & State, or foreign country) <i>U S A</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>					
13. FATHER'S NAME <i>Harry Van Newkirk</i>				14. MOTHER'S MAIDEN NAME <i>Catherine (Unk)</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>162-01</i>				17. INFORMANT <i>Mrs. Margaret Outten Newkirk (Wife) 103 New York Ave, Salisbury, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>162-01</i> DUE TO <i>Branchopneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Branchogenic Carcinoma of</i> DUE TO <i>Left Lung with metastases</i> (c) <i>1 year</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Marked Emphysema of lungs</i>											
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Hour <i>e.m.</i> <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 1961</i> to <i>Feb 6 1962</i> , that (I) (we) last saw the deceased alive on <i>Feb 6 1962</i> and that death occurred at <i>5:45 P.M.</i> from the causes and on the date stated above.											
22a. SIGNATURE <i>Paul G. Cayaves</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>2-7-62</i>			
22c. PHYSICIAN'S NAME (Type) <i>PAUL G. CAYAVES</i>				22d. ADDRESS <i>222 N. Division St, SALISBURY, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb. 9, 1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>HOLLOWAY &amp; COMPANY</i>				ADDRESS <i>SALISBURY, MARYLAND</i>				25a. REC'D BY REGISTRAR DATE <i>FEB 9 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Thane</i>	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02532

Reg. Dist. No.

02543

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>605 Oak Hill Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SARAH</b> First <b>PARKER</b> Middle <b>PARKER</b> Last		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>28th</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 21, 1884</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Parsonsborg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Elisha P. Wilkins</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Dickerson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>12-XXXX-XXXX</b>	
17. INFORMANT <b>Mrs. Beatrice Shull (Daughter)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4x22</b> DUE TO <b>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Degeneration</b> (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 4/1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY, MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 5 '62</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: John Doe

2. SEX: Male

3. AGE: 45

4. OCCUPATION: Teacher

5. PLACE OF BIRTH: Washington, D.C.

6. DATE OF DEATH: Jan 15, 1925

7. TIME OF DEATH: 10:30 AM

8. PLACE OF DEATH: Home

9. CAUSE OF DEATH: Heart failure

10. MANNER OF DEATH: Natural

11. SIGNATURE OF EXAMINER: [Signature]

12. SIGNATURE OF ATTENDING PHYSICIAN: [Signature]

13. SIGNATURE OF CORONER: [Signature]

14. SIGNATURE OF JURY: [Signature]

15. SIGNATURE OF WITNESSES: [Signature]

16. SIGNATURE OF DECEASED: [Signature]

17. SIGNATURE OF NEXT OF KIN: [Signature]

18. SIGNATURE OF BURIAL OFFICIAL: [Signature]

19. SIGNATURE OF FUNERAL HOME: [Signature]

20. SIGNATURE OF CEMETERY: [Signature]

21. SIGNATURE OF CHURCH: [Signature]

22. SIGNATURE OF OTHER: [Signature]

23. SIGNATURE OF OTHER: [Signature]

24. SIGNATURE OF OTHER: [Signature]

25. SIGNATURE OF OTHER: [Signature]

26. SIGNATURE OF OTHER: [Signature]

27. SIGNATURE OF OTHER: [Signature]

28. SIGNATURE OF OTHER: [Signature]

29. SIGNATURE OF OTHER: [Signature]

30. SIGNATURE OF OTHER: [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS; 301 W. PRESTON STREET, BALTIMORE, MARYLAND

## CERTIFICATE OF DEATH

02544

02588

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pen Gen. Hospital</b>			d. STREET ADDRESS <b>120 Olive St</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>WILLIAM FRANCIS PENNEWELL</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>24</b> Year <b>19 62</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 27, 1885</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cape Charles, Virginia</b>	
13. FATHER'S NAME <b>George Pennewell</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unk</b>			14. MOTHER'S MAIDEN NAME <b>Mary Jane Disharoon</b>		
16. SOCIAL SECURITY NO. <b>Unk</b>			17. INFORMANT <b>Mr. Fred K. Adkins (Brother-In-Law)</b> Address <b>120 Olive Street Salisbury, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchitis pneumonia</b> <b>904.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rhachis of ribs</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 weeks -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>	
20f. (City or town) <b>N/A</b>		20g. (County) <b>N/A</b>		20h. (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from..... 19..... to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 5:30 P.M. .... from the causes and on the date stated above.					
22a. SIGNATURE <b>William H. Fisher, Jr.</b> M.D.			22b. DATE SIGNED <b>Feb. 26 / 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. William H. Fisher, Jr.</b>			22d. ADDRESS <b>Medical Center Salisbury, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 27, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b>		23e. (State) <b>Salisbury, Maryland</b>		23f. (County) <b>Salisbury, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>			24b. ADDRESS <b>SALISBURY, MARYLAND</b>		
25a. REC'D BY REGISTRAR DATE <b>MAR 2 '62</b>			25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			
a. COUNTY				e. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN <i>Salisbury</i> c. LENGTH OF STAY IN 1b <i>16 Days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>G. G. Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <i>md</i> b. COUNTY <i>Worcester</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> d. STREET ADDRESS <i>23X-2</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>John Paul Perkins</i>				4. DATE OF DEATH Month Day Year <i>Feb. 14 1962</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 2-1897</i>	
9. AGE (In years last birthday) <i>64 1/2</i>		10. BIRTHPLACE (County & State, or foreign country) <i>Centerville, Md.</i>		11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Lewis H. Perkins</i>				14. MOTHER'S MAIDEN NAME <i>Ida Jane Burns</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>117-01-6458</i>			
17. INFORMANT <i>Mrs. Evelyn Perkins</i>				Address <i>Snow Hill md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Posterior Coronary Thrombosis</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Diabetes Mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bleeding Benign Gastric ulcer</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 hours</i> <i>Years</i> <i>Years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 14</i> , 19 <i>61</i> , to <i>Feb 14</i> , 19 <i>62</i> ; that (I) (we) last saw the deceased alive on <i>Feb 14</i> , 19 <i>62</i> , and that death occurred at <i>11 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>David Rafat</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>DAVID RAFAT M.D.</i>				22d. ADDRESS <i>Snow Hill Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Feb. 17/62</i>				23b. NAME OF CEMETERY OR CREMATORY <i>Bates Methodist</i>		23c. LOCATION (City, town or county) (State) <i>Snow Hill md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mayer Gummis</i>				25a. REC'D BY REGISTRAR <i>Feb 19 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Charles L. Krum</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02546

02535

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico County</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb <u>655 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		d. STREET ADDRESS <u>RFD 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Irene</u> Middle <u>--</u> Last <u>PHILLIPS</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>1</u> Year <u>1962</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1921</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen J. Stonom</u>				14. MOTHER'S MAIDEN NAME <u>Raggar Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>266-306-534</u>		17. INFORMANT <u>Stephen J. Stonom, Defuniak, Fla.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of cervix uteri with extended metastases to pelvic organs</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 18, 1960</u> to <u>Feb. 1, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 1, 1962</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>		M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>2/2/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/7/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 6 '62</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Wicomico		MARYLAND		DELAWARE		SUSSEX	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
SALISBURY		PENINSULA GENERAL HOSPITAL		DELMAR		46X-3	
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
JOHN LEE		PHILLIPS		FEBRUARY 2 1962			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-24-1899	62 yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
FARMER		OWNER		DELMAR - DEL USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
J DAVIS		ALLIE F. HEARN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
NO		222-07-1476		Marie W. Phillips, Delmar Del			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
420.1 Coronary Artery Thrombosis		4 hrs.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Coronary Atherosclerosis		Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		Anteriosclerotic Heart Disease (Congestive Failure)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from 2/2 1962 to 2/2 1962, that (I) (we) last saw the deceased alive on 2/2 1962, and that death occurred at 2:30 AM, from the causes and on the date stated above.		22a. SIGNATURE M.D.		22b. DATE SIGNED			
Hand J. Silburne							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		2-4-62		Sebron		Sebron, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W S Marshall Co - Delmar Del				DATE FEB 6 '62		Arthur S. Krause	

05282

05282



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02548

02538

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN lb <b>12</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Pen Gen Hospital</b>				d. STREET ADDRESS <b>S. 112 Naylor Street</b>			
3. NAME OF DECEASED (Type or print) <b>MILLARD PALMER REED</b>				4. DATE OF DEATH <b>FEBRUARY 19th 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 23, 1898</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Body Repair (Body Shop)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Bridgeville, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Robert B. Reed</b>				14. MOTHER'S MAIDEN NAME <b>Jane Adams</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs. Virginia M. Reed (Wife) 112 Naylor St Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>2000</b> DUE TO <b>Reticulum Cell Sarcoma</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Occlusion</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>N/A</b> 19 p.m. <b>N/A</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> <b>1962</b> to <b>2/19</b> <b>1962</b> that (I) (we) last saw the deceased alive on <b>2/19</b> <b>1962</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas C. Hill Jr. M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 20/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill</b>				22d. ADDRESS <b>Pine Bluff Road-Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 21, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY - SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

02548

CERTIFICATE OF DEATH

02548

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02539  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D.# 1 (Richardson Rd)</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LINWOOD ELLEN RICHARDSON</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>26</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1886</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>26</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Willards, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Peter Sidney Richardson</b>		14. MOTHER'S MAIDEN NAME <b>(Mariah Ellen Byrd Parsons)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>U. INFORMANT Mrs. Grace Alma (Parker) Richardson (Wife) R.D.#1 Willards, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 - DUE TO - Arterio-sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Occlusion</b> causing the underlying cause last. (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>407 Camden Ave. Salisbury, Md</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Feb. 26 /1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Dennis Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Willards, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAR 2 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02550

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02540

Item 7 Film G307 2/20/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>	
c. LENGTH OF STAY IN lb		d. STREET ADDRESS <b>Route # 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Deers Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Riggin</b>		4. DATE OF DEATH <b>2-7-62</b> 19 <b>62</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-1886</b> 75 <b>rs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Sewell Dryden</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Dykes</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>I</b>	
16. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT <b>Mrs. Lucy Powell, Princess Anne, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Subar Bronchitis</b> 82 <b>EX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of Ribs Rt. Eyeball</b> DUE TO <b>effusion</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Concussion</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car that ran off road and threw her out.</b>	
20c. TIME OF INJURY Month, Day, Year <b>12-17-61</b> 19 <b>61</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>Pocomoke</b> (County) <b>Worcester</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		DATE SIGNED <b>2-9-62</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/10/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Perryhawkin</b>		22d. LOCATION (City, town, or country) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR <b>James H. Huxman</b>		24a. REC'D BY REGISTRAR <b>FEB 15 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huxman</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

2000-01-01

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

• 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02551

02541

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23X-2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Amanda Burton Ringle</u>				4. DATE OF DEATH <u>February 26 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13, 1886</u> 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Rickards</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Hickman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes give war or dates of service) <u>XX</u>				17. INFORMANT <u>Mrs. Lida Steele Berlin, Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4-20-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-12</u> , 19 <u>62</u> to <u>2-26</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2-26</u> , 19 <u>62</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William A. Ellis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-26-62</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 3/1/62</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows</u>		23d. LOCATION (City, town or county) (State) <u>Bishopville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>				25a. REC'D BY REGISTRAR <u>Mar 1 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hirsch</u>	

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MEDICAL CERTIFICATION

05211

05231



John M. Kelly, Esq.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02552

## CERTIFICATE OF DEATH

02542

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAMES QUARTER</u> <span style="float: right;">19X-2</span> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Allen James Shores</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>22</u> Year <u>1962</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>MAY 5-1884</u> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>9</u> Days <u>17</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired-Waterman</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Fishing</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Somerset Co. Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>William J. Shores</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret <del>XXXXX</del> Carew</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u></u> <b>17. INFORMANT</b> <u>Mrs. Wm. J. Stewart (Daughter)</u> <u>100 Berwyn Rd Blackwood, New Jersey</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-renal Failure due to Arteriosclerosis</u> <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u> <b>20f. (City or town)</b> <u></u> <b>(County)</b> <u></u> <b>(State)</b> <u></u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2-19-62</u> , 19 <u>62</u> , <b>to</b> <u>2-22-62</u> , that (I) (we) last saw the deceased alive on <u>2-21-62</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Carrie Hearn</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>2-22-62</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>CARRIE HEARN</u> <b>22d. ADDRESS</b> <u>226 N. Dimes in St Salisbury Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 26, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Shores Family Cemetery</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOLLOWAY &amp; COMPANY</u>		<b>ADDRESS</b> <u>SALISBURY, MARYLAND</u>		<b>25a. REC'D BY REGISTRAR</b> <u></u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hearn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

(M)

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No

08212

08212

James C. Hester

James C. Hester

James C. Hester

Allen James

White white

Robert James

James C. Hester

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James C. Hester

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02553

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02543

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deal Island</b>		d. STREET ADDRESS <b>198-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hubbert</b> Middle <b>R</b> Last <b>Shores</b>				4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>62</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/94</b>		9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lambert Shores</b>				14. MOTHER'S MAIDEN NAME <b>Emma Shores</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>John Fisher</b>		Address <b>Deal Island, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>9030</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anemia, secondary</b> DUE TO (c) <b>Hepatitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>yes</b> <b>yes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture R. hip</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from home</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1-22</b> p.m. <b>52</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Deal Island</b> (County) <b>Somerset</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Earl L. Royer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>2/16/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Meth. Ceme.</b>	
23. FUNERAL DIRECTOR <b>Leroy G. Webster</b>				ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 21 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>William S. Hanks</b>		24c. REGISTRAR'S NAME <b>William S. Hanks</b>	

05418

05418

Afternoon  
Lecture, Wednesday  
Hepatitis

Contingent help

Full time hours

Revised 2/11/12

Earl L. Rogers 2+122nd St. 5-11-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02554

## CERTIFICATE OF DEATH

02544

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover, Maryland. R F D. 19x-2</u>	
c. LENGTH OF STAY in lb <u>Life Time</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Evulina</u> Middle <u>Shreeves</u> Last <u>Shreeves</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>II/3/1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>Nelson Collins</u>		14. MOTHER'S MAIDEN NAME <u>Zelphia Coston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Martin, Bronx, N Y.</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis and</u> (c) <u>Hypertension</u> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 3</u> 1962 to <u>Feb 12</u> 1962, that (I) (we) last saw the deceased alive on <u>Feb 11</u> 1962, and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		22b. DATE SIGNED <u>2/12/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Pine Bluff Road, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/17/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones</u>		25a. REC'D BY REGISTRAR <u>  </u> DATE <u>FEB 20 1962</u>	
ADDRESS <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02555

02545

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>5 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> d. STREET ADDRESS <u>700 S. DIVISION</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>JAMES GORMAN SMITH</u>				<b>4. DATE OF DEATH</b> <u>February 23, 1962</u>			
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JAN. 12, 1911</u>	
<b>9. AGE</b> (In years last birthday) <u>51</u> yrs.         IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>EDWARD J. SMITH</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>RUTH B. WASH BURN</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>YES</u> <u>W.W.II</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>220-01-8767</u>		<b>17. INFORMANT</b> <u>MRS. MARY L. SMITH</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO (b) <u>Intestinal coronary occlusion</u> DUE TO (c) <u>Generalized bronchopneumonia - left.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Statin arteriosclerosis</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>7 hrs</u> <u>?</u> <u>3 days</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>				<b>20g. (County)</b>			
<b>20h. (State)</b>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1957</u> to <u>2/23</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>62</u> , and that death occurred at <u>7:00</u> A.M. from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>William D. Gray</u> M.D.				<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>WILLIAM D. GRAY MD</u>				<b>22d. ADDRESS</b> <u>CAMDEN AVE. SALISBURY, MD.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2/26/1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>SPR. HILL MEM. GARD.</u>		<b>23d. LOCATION</b> (City, town or county) <u>HEBRON, MD.</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HILL &amp; JOHNSON Co.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MAR 2 '62</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>George C. Hill, Jr.</u>				<b>25c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

VR A15 (4)  
15M 9/60



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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3  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02556 02546

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Horsey</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>John Shepperd Smith</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer Truck Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Custis Smith</u>		14. MOTHER'S MAIDEN NAME <u>Rose Ann Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-34-3293</u>	
17. INFORMANT <u>Mrs. Elizabeth Smith</u>		Address <u>Jenkins Bridge Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> DUE TO <u>572</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of diverticulum of sigmoid</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/7/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Jenkins Bridge Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Jenkins Bridge, Va.</u>	
23. FUNERAL DIRECTOR <u>Fox &amp; FANETAL</u>		24a. REC'D BY REGISTRAR <u>Home Temperanceville, Va.</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kinne</u>		DATE <u>FEB 13 '62</u>	

MEDICAL CERTIFICATION

08228

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*Handwritten signature or initials.*

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FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 02557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02547

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <u>Willards</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Walter</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>62</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-28-1900</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XX Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Smith</u>		14. MOTHER'S MAIDEN NAME <u>Bell Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT <u>Chester Smith Pittsville, Md.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of brain</u> 976 X DUE TO (b) <u>Shot self anterior to right ear.</u> DUE TO (c) <u>Shot self anterior to right ear.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>2-7-62</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home</u>	
20f. (City or town) <u>Willards</u>		20g. (County) <u>Wicomico</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>2-12-62</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER'S SIGNATURE <u>Earl L. Royer</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/13/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>	
22d. LOCATION (City, town, or country) <u>Willards</u>		22e. (State) <u>Md.</u>		22f. REC'D BY REGISTRAR <u>Willards</u>	
23. FUNERAL DIRECTOR <u>Peter Whaley</u>		ADDRESS <u>Salisbury</u>		DATE <u>FEB 15 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



*File 100*

*Mr. [illegible]*



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02558  
CERTIFICATE OF DEATH  
02548

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Fruitland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.D.# 1 Salisbury Route</u>			
3. NAME OF DECEASED (Type or print) <u>Lucia Stanbury</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <u>Feb. 27 1962</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (House Work)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>				12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Unk Hill</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				17. INFORMANT <u>Mr. Arthur M. Lockwood (Friend) R.D.# 1 Brown St. (Fruitland) Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rift cerebral Hemorrhage</u> 422 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Degenerative Cardiovascular Disease</u> (c) <u>Cerebral Arteriosclerosis</u> DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (His/Her) attended the deceased from <u>Jan 14, 1961</u> to <u>Feb 27, 1962</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>Feb 26, 1962</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>George H. Henning M.D.</u> 22b. DATE SIGNED <u>2/28/62</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Henning</u> 22d. ADDRESS <u>Medical Center - Salisbury, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Mar. 2, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fruitland Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Fruitland, Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u> 25a. REC'D BY REGISTRAR <u>MAR 5 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02559 CERTIFICATE OF DEATH 02549											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hallwood, Va</u> <u>83X-3</u>					
c. LENGTH OF STAY IN TB						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Joseph Thomas Stant</u>						4. DATE OF DEATH <u>February 25 1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 6th 1877</u> <u>84</u> yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Employee Packing House</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Sanford Va</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Major Stant</u>					
14. MOTHER'S MAIDEN NAME <u>Caldelia Stant</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					
16. SOCIAL SECURITY NO. <u>898</u>						17. INFORMANT <u>Amelia J. Buell Hallwood, Va</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> , 19 <u>62</u> , to <u>2-25</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>62</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Amelia J. Buell</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Amelia J. Buell</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-27-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Davenings</u>		23d. LOCATION (City, town or county) (State) <u>Oak Hall, Va</u>		25a. REC'D BY REGISTRAR			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kubert D. Teister</u>						ADDRESS <u>Accomack, Va</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>		DATE <u>FEB 28 '62</u>	

05013

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Wichita

General

General Hospital

To Joseph Thomas, 2nd

White

White

White

White

Antineoplastic Agent

1955

Antineoplastic Agent

Antineoplastic Agent

Antineoplastic Agent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02560					02550									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)									
a. COUNTY Wicomico MARYLAND					a. STATE Maryland b. COUNTY Prince George's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 2,321 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Washington, D. C. 1621-2			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital					d. STREET ADDRESS 5000 Suitland Road									
3. NAME OF DECEASED					4. DATE OF DEATH		5. RESIDENCE							
First Middle Last Mary E. Taylor					Month Day Year Feb. 2 19 62									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1883		9. AGE (In years last birthday) 78 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK		10b. KIND OF BUSINESS OR INDUSTRY UNK		11. BIRTHPLACE (County & State, or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U S A								
13. FATHER'S NAME Charles Augustus Knockey					14. MOTHER'S MAIDEN NAME - - - - - Ward									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO. 579-03-7402					17. INFORMANT Mr. Alfred Irving Taylor (Husband) Lakeland Fla. & Deer's Head Hosp. Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Pulmonary edema (b) H-ASEVD (c) DUE TO years					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury, Maryland		(County) Wicomico		(State) Maryland		
21. I certify that (I) (this hospital) attended the deceased from Sept. 26, 1955, to Feb. 2, 1962 that (I) (we) last saw the deceased alive on Feb. 1, 1962, and that death occurred at 4:06 A.M., from the causes and on the date stated above.										22b. DATE SIGNED 2/2/62				
22a. SIGNATURE L. V. Maldve, M. D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.					22d. ADDRESS Deer's Head Hospital; Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 9, 1962		23c. NAME OF CEMETERY OR CREMATORY Wico. Mem. Park			23d. LOCATION (City, town or county) Salisbury, Maryland			(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY					ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR FEB 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					



HOLLAND & COMPANY, BIRMINGHAM, ENGLAND

NEW YORK, N. Y.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02561

02551

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY in 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>				e. STREET ADDRESS <b>725 CAMDEN AVE</b>			
3. NAME OF DECEASED (Type or print) <b>Seth Patterson Taylor</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1962</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/8/1897</b>	
9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>LAW</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WAMES I. TAYLOR</b>				14. MOTHER'S MAIDEN NAME <b>MARY D. ANDERSON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>215-38-1177</b>		17. INFORMANT <b>MRS. CHARLOTTE TAYLOR, SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>4201 Coronary Artery Thrombosis</b>							
DUE TO (b) <b>4201</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>4201</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>2/8</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-8</b> , 19 <b>62</b> , and that death occurred at <b>3:30</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>David J. Gilmore</b>				M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/8/1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID J. GILMORE</b>				22d. ADDRESS <b>MEDICAL CENTER, Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/10/1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HILL &amp; JOHNSON</b>				ADDRESS <b>SALISBURY, MD</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 '62</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02552

02562

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>1007 Cecil Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>JAMES</b> Last <b>TINGLE</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12th</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 10, 1922</b>
9. AGE (In years lost birthday) <b>39 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Broiler Service) Chickens</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Vac. of</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles H. Tingle</b>		14. MOTHER'S MAIDEN NAME <b>Annie Jane Dennis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.# II</b>	
17. INFORMANT <b>Mrs. Margie V. Tingle (Wife)</b>		Address <b>1007 Cecil St Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Metastatic Embolus.</b> DUE TO <b>Carcinomatosis of Rt Lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>N/A</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>N/A</b> 19 p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N/A</b>		20f. (City or town) (County) (State) <b>N/A</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>April 19 66</b> to <b>2/12/62</b> , that (I) (we) last saw the deceased alive on <b>2/12/62</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Carrie I. Hearn</b>		22b. DATE <b>Feb. 13 / 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>		22d. ADDRESS <b>N. Division St. Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 15, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		25a. REC'D BY REGISTRAR <b>FEB 14 '62</b>	
ADDRESS <b>SALISBURY, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02563

02553

1. PLACE OF DEATH a. COUNTY <b>Wicomico County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent County</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>1645 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>---</b>	
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>H.</b> Last <b>TRINKS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1877</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months <b>14</b> Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Flour Mill</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Trinks</b>		14. MOTHER'S MAIDEN NAME <b>Anna Hoge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Edwin R. Trinks</b>		Address <b>Worton, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pyelonephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Diabetes mellitus</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>Aug. 27, 1957</b> , to <b>Feb. 27, 1962</b> that (I) (we) last saw the deceased alive on <b>Feb. 27, 1962</b> , and that death occurred at <b>1:25 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee L. Lawry</b>		22b. DATE SIGNED <b>2/27/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee L. Lawry, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-2-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Still Pond Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Still Pond Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '62</b>	
ADDRESS <b>Still Pond, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

(M)

02553

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CERTIFICATE OF DATE

James G. Smith

James G. Smith

Calgary

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James G. Smith

James G. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
02564		Item 9 Film G307		2/15/62		1st		02554					
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN lb <i>Maryland</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Ocean City</i> d. STREET ADDRESS <i>103 Caroline Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Infant</i>				4. DATE OF DEATH Last First Middle <i>Wallace</i> Month Day Year <i>February 7 1962</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>February 7, 1962</i>		9. AGE (In years last birthday) — yrs. Months Days <i>— 12 39</i>		IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Salisbury Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Scott Wallace Jr.</i>				14. MOTHER'S MAIDEN NAME <i>Sally Elizabeth Rayne</i>				Address <i>Mrs. Scott Wallace Jr Ocean City Md</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Mrs. Scott Wallace Jr</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <i>Massive Intracranial Hemorrhage</i> <i>760.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Diaphragmatic Hernia and Prematurity</i>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		Month, Day, Year <i>2/7</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Salisbury Md</i>		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>2/7</i> to <i>2/7</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>2/7</i> , 19 <i>62</i> and that death occurred at <i>6:30</i> A.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>William C. Morgan</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>2/7/62</i>					
22c. PHYSICIAN'S NAME (Type) <i>Salisbury Md</i>				22d. ADDRESS <i>Salisbury Md</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE THEREOF <i>2/9/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN</i>		23d. LOCATION (City, town, or county) <i>Berlin Md</i>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Russ R. Bubger</i>				ADDRESS <i>Berlin Md</i>				25a. REC'D BY REGISTRAR <i>Feb 13 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02565

02535

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY in lb <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEAL ISLAND</b> d. STREET ADDRESS <b>MAIN ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT JAMES WALLACE</b>		4. DATE OF DEATH Month Day Year <b>February 8 - 1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 16 - 1881</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>JOHN WALLACE</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA BARKLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INSURANT <b>Rosena Wallace Deal Island Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Pyelonephritis, and Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>due to Proteus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/29</b> , 19 <b>62</b> to <b>2/8</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/8</b> , 19 <b>62</b> , and that death occurred at <b>2:45</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill, Jr.</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE SIGNED <b>2/11/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Hill, Jr.</b>		22d. ADDRESS <b>Pine Bluff Road, Salisbury Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>2-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley Methodist</b>	23d. LOCATION (City, town or county) (State) <b>Deal Island Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>L. G. Webster</b>		ADDRESS <b>Funerals</b>	
25a. REC'D BY REGISTRAR <b>FEB 19 62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur G. H.</b>	

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1. The first step is to identify the problem or question that needs to be answered.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02566

## CERTIFICATE OF DEATH

02556

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Wicomico County</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Somerset County</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1796 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		d. STREET ADDRESS <b>Oak Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Edna May WALLER</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>18</b> Year <b>19 62</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Dec. 28, 1895</b>	<b>9. AGE</b> (In years last birthday) <b>66 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>	<b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Heath</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Louisiana Heath</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Mrs. Clyde Jenkins, Princess Anne, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal hemorrhage</b> DUE TO (b) <b>Polycythemia vera</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <input type="checkbox"/> e.m. <input type="checkbox"/> p.m.	Month, Day, Year <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> et work <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	(County)	(State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>March 20, 1957</b> <b>to February 18, 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Feb. 18, 1962</b> , <b>and that death occurred at</b> <b>10:45 P.M.</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>L. V. Maldve, M. D.</b>		<b>22b. ADDRESS</b> <b>Deer's Head State Hospital Salisbury, Maryland</b>		<b>22c. DATE SIGNED</b> <b>2/19/62</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2/21/62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Andrews Episcopal</b>		<b>23d. LOCATION</b> (City, town or county) <b>Princess Anne, Md.</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Levin R. Wilson, Princess Anne, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 23 '62</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Knaus</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
02567 CERTIFICATE OF DEATH 02557										
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b <b>615 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			d. STREET ADDRESS <b>924 S. Division Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Marie</b> Last <b>Wilbert</b>					4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>19 62</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1886</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Marvin V. Gates</b>					14. MOTHER'S MAIDEN NAME <b>Venora Fields</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>11-25 P.M.</b>					
17. INFORMANT <b>Mrs. C. Marie Derrickson (Grand-Daughter)</b> <b>419 E. 6th Street Laurel, Delaware</b>					Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b> (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>Years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1960, to Feb. 6, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 6, 1962</b> , and that death occurred at <b>11:25 P.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/7/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>					22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>					
23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 10, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church of the Open Door Cemetery-Clarksville, Del.</b>		23d. LOCATION (City, town or county) (State)				
24 FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</b>					ADDRESS <b>SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. P. ...</b>	

05337

CERTIFICATE OF

1888



HOLLOWAY & COMPANY, BATHURST, HAWAII

Serial 10, 1002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02568					02558									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)									
a. COUNTY		Wicomico			a. STATE		Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury			b. COUNTY		Wicomico							
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		12 Salisbury							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?							
100 E. William St					108 E. William St		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED					4. DATE OF DEATH									
First Middle Last					Month Day Year									
A. DOROTHEA WILCOX					FEBRUARY 16 19 62									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Female		White				February 3, 1881		81 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
Retired Ins. Agent		Insurance		(Mt. Pleasant) Wilmington, Delaware		U S A								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
George W. Wilcox					Emma L. Matthews									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
No										Deceased - Miss A. Dorothea Wilcox				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)														
157X DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Carcinoma of Pancreas				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
					N/A									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
N/A 19							N/A		N/A					
21. I certify that (I) (this hospital) attended the deceased from 19..... to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.														
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS		Feb. 18 / 1962							
Dr. Zack J. Waters					Medical Center - Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			Feb. 19, 1962		Parsons Cemetery			Salisbury, Maryland						
24 FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
HOLLOWAY & COMPANY - SALISBURY, MARYLAND							DATE FEB 19 '62		Arthur L. Kraus					

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CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 02569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02559

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Delaware</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>R F D # 1</b>			
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Workman</b>				4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>62</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 21, 1905</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Larry C. White</b>				14. MOTHER'S MAIDEN NAME <b>Maude E. Kinikin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Olin J. Workman, Delmar, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 420 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arterio-sclerotic heart disease</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22b. DATE THEREOF <b>2-24-62</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>			
22d. LOCATION (City, town, or country) (State) <b>Laurel, Delaware</b>				22e. LOCATION (City, town, or country) (State)			
23. FUNERAL DIRECTOR ADDRESS <b>W.S. Marvel Co. Delmar, Del.</b>				24a. REC'D BY REGISTRAR <b>FEB 26 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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*[Handwritten signature]*